



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NIX HEALTH CARE SYSTEM
414 NAVARRO SUITE 1720
SAN ANTONIO TX 78205

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative

Box Number 54

MFDR Tracking Number

M4-13-2621-01

MFDR Date Received

JUNE 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim had denied for no prior authorization on file. When [injured employee] came into our facility on 05/04/12 she presents her insurance card and did not inform us that this was supposed to be bill [sic] under her workers' compensation. We were no [sic] informed till after the surgery was done and that was on 06/05/2012 and did not get the workers' comp information till 6/25/2012 from doctor's office."

Amount in Dispute: \$17,532.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual reviewed its claim file and found (B)(i-iii) do not apply. One year from disputed date 5/6/12 is 5/6/13. The TDI/DWC date stamp lists the received date as 6/13/13 on the requestor's DWC-60 packet, a date greater than one year from 5/6/12. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual Insurance Co., 62210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2012 through May 6, 2012	Hospital Outpatient Services	\$17,532.90	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – Precertification/authorization/notification absent.
 - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute is May 4, 2012 through May 6, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 13, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

October 24, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.